# PROCEEDINGS OF THE DUBLIN OBSTETRICAL SOCIETY.

## FORTY-SECOND ANNUAL SESSION.

EDWARD B. SINCLAIR, A.M., M.D., President.
WILLIAM ROE, M.D., Honorary Secretary.

*Saturday, April 3, 1880.*

E. B. SINCLAIR, A.M., M.D., President, in the Chair.

*Exhibition of a Monster born in the Rotunda Lying-in Hospital.*

DR. ATTHILL said: On being called to see a woman in labour I found protruding from the vulva a portion of intestines like those of an adult. I understood that the patient had been upwards of twelve hours in labour, under the care of a midwife, who had brought her to the hospital. The presumption on my mind was that rupture of the uterus had taken place; that the midwife had pulled down the woman's intestines, and that the patient was moribund. On feeling her pulse I was surprised, however, to find that it was quiet and regular, and I at once saw that my suspicion of improper treatment was unjust. On passing my hand into the vagina I found that I could trace the intestines inside the os uteri, and could feel nothing else except an irregular mass. I was then satisfied that I was dealing with a monster. I also felt an arm, and passing up a blunt hook I got it over the child's shoulder, and, without any very great difficulty, delivered the woman of this monster, notwithstanding that the head is of very large size. It will be seen that the entire of the lower anterior portion of the abdominal wall is wanting, the intestines and the liver are free, and the legs are malformed. As far as I am aware the specimen is unique. I thought it to be of medico-legal interest, as a case that might have been mistaken for the result of malpractice or accident. The child was dead. The protruded intestines were immensely distended, and as large as those of an adult.

DR. ATTHILL also exhibited two intra-uterine polypi which were taken from an unmarried woman, aged thirty-five.

*Acute Hydramnios.* By ALFRED H. M'CLINTOCK, M.D.

As dropsy of the amnion is not a rare disease, and, moreover, as it formed the subject of a valuable communication from Dr. Kidd, not long ago, my remarks will necessarily be somewhat restricted. I wish chiefly

to direct attention to what may be called the *acute* form of the disease. In the mild or chronic cases, which are those most commonly met with, the patient has little to complain of beyond the unusual size and weight of the uterine tumour, the accompanying symptoms not being such as to give rise to any serious indisposition, or to any alarm respecting her state.

Now it is of some importance to know that the disease is capable, on rare occasions, of producing a train of symptoms not only most distressing to the patient herself, but sufficiently grave to awaken fears for her safety in the minds of her friends, or even of her medical attendant. To be able to recognise these symptoms, and trace them to their true source, and so to pronounce a correct prognosis, is a matter of some consequence.

The pathological cause of dropsy of the amnion has not yet been clearly made out. On this part of the subject I regret to say that I have nothing new to offer. In the cases about to be related, while the amnion itself presented no appreciable morbid appearance, the placenta deviated considerably from its normal condition, being greatly enlarged, pale, remarkably soft, and evidently œdematous.

Simpson made the observation that diseases of the placenta are very apt to recur in the same individual, and my own experience strongly corroborates this. Such a fact suggests a probability of the disease having, in some degree at all events, a constitutional origin.

It is asserted, by Lange I think, that an œdematous condition of the placenta—to which I have already alluded—is present in all instances of amniotic dropsy. If this be not the strict truth, it certainly is not far removed from it, as in nearly all the cases of the disease in question which have come under my notice, the placenta exhibited more or less of a morbid condition. For this reason, and also because the vascular nutrient supply of the amnion would seem to be derived from the placenta, I am led to believe that in the great majority of cases the dropsical effusion into the amniotic sac has its primary cause in the afterbirth. At the same time I would be slow to deny that inflammation of the amnios may sometimes produce the dropsy. This qualifying statement I make in deference to the authority of M. Mercier, who ably advocated this view, and supported it by some highly illustrative cases.

I shall now briefly lay before you the leading features of three cases, which will serve as good illustrations of the *acute* form of dropsy of the amnion.

Case I.—In the spring of 1878 a lady engaged me to attend her at her tenth confinement, which she expected about the 20th of July, dating from the last appearance of the catamenia. Her first and second children were born alive, at the full time, and have survived, but all her succeeding pregnancies—and they were seven in number—had terminated prematurely, the children being dead, and more or less decomposed,

with an excessive quantity of liquor amnii. She had been subject at times to bronchitis, but beyond this both she and her husband were very healthy.

During the month of May her size rapidly augmented. She suffered much from loss of sleep, restlessness, flushings, palpitation, heat of hands, headache, and pyrexia, with extreme rapidity of pulse; abdominal pains, and general malaise. There was some œdema of the lower extremities, but no trace of albumen in the urine.

On the 1st June (that is, about six weeks before the expected period) she fell in labour, and after some hours expelled a small male child, far gone in decomposition, but not exhaling any fœtid odour. There was an enormous quantity of thick offensive liquor amnii. Considerable hæmorrhage ensued, and I had to extract the placenta, which was fully three times the normal bulk, œdematous, pale, soft as porridge, insomuch that it required the hand to be passed into the uterus three several times to effect its removal; and, even so, some fragments remained behind, and were discharged in the course of the next few days. She recovered slowly, but perfectly, and quite regained her health.

Case II.—Last May (1879) this lady again conceived, and up to the period of quickening, or thereabouts, enjoyed unusually good health. Soon after this I put her on the use of chlorate of potassium and iron, which very much disagreed with her, and had to be discontinued. I then tried both these remedies separately, but with no better result. Early in December she began to notice a rapid increase of her size, and at same time all her old symptoms came on with great acuteness. The pulse never was below 100, and on the slightest excitement, or after any stimulant however mild, it got up to 120 or 130, with general heat and thirst; she had frequent abdominal pains, slept badly, and had no appetite. Her condition now became extremely distressing, as she had no respite from pain, or annoyance of one kind or another, and she was entirely confined to bed or the sofa. Nothing I could do gave her any ease, except morphia in small quantity, which relieved the abdominal pains, and procured her some sleep. Her husband and friends now became so much alarmed at her weakness, constant pain, and persistent rapidity of pulse, &c., that Dr. M'Donnell was asked to meet me in consultation, with a view to see if there could be any cause for these symptoms other than the gravid state. None such, however, could be discovered on the most careful investigation. Towards the middle of December, and when she was about six and a-half months gone, her size exceeded that of a normal pregnancy at full period. On the 28th December labour pains set in. As soon as the os was nearly fully dilated—no presentation being then tangible—I ruptured the membranes, and found a leg presenting. This I seized and brought down, and quickly extracted a decomposed male fœtus. There were several pints of liquor amnii. The placenta

was enormously large, but not quite so pale or soft as on the last occasion, and was expelled without any direct manual interference.

She recovered perfectly, but what struck me as being most remarkable was the rapidity—I might almost say the suddenness—with which all her distressing symptoms subsided from the very moment of delivery; so that her convalescence was in the highest degree satisfactory.

I was much disappointed in this case, at the signal failure of a line of treatment which has proved on many occasions so successful in preserving the life of the fœtus.

CASE III.—About the time the last labour occurred, another lady, from a distant part of Ireland, came under my notice, whose obstetric history was as follows:—In her first pregnancy she went to term, and was confined, under my care, of a daughter, dead, but evidently not more than two or three days so. Its death seemed attributable to the accidental separation of a part of the afterbirth, and hæmorrhage consequent thereon. Her second child was a boy born alive at term; her third child also a boy born alive at full time; her fourth child a girl, born weakly, and died jaundiced, on the third day; her fifth was a boy, born prematurely, and dead for some days previously; the quantity of liquor amnii on this occasion was greatly in excess. Her sixth was also a boy, and born dead under exactly the same circumstances as the last, with the addition of hæmorrhage *post partum*. Three months after this confinement she came to me to be treated for uterine catarrh, abrasion of the os uteri, and slight posterior misplacement of body of the womb. After a couple of months she was much improved and again conceived—this being her *seventh* pregnancy. Soon after quickening I began to try my favourite remedies of chlorate of potassium and iron, separately and combined, under every possible form, in the hope of prolonging gestation or saving the life of the fœtus. But, as in the former case, they disagreed so much that I had, very reluctantly, to relinquish their administration altogether. From the commencement of this pregnancy she had remarked her size to be greater than on any former occasion; but towards the middle of the sixth month she noticed the uterine tumour to undergo a rapid increase of bulk; and about the same time she began to experience loss of appetite and sleep, thirst, and feverishness at times most distressing. There was a constant feeling of restlessness and discomfort, so that she was deprived of all enjoyment, and spent her time in bed or on the sofa. Somewhat later she had frequent abdominal pains evidently due to uterine contractions. There was also slight œdema of the feet and ankles, and the urine showed a faint cloud of albumen. I tried the effect of different remedies—such as diuretics, febrifuges, anodynes, &c.—but without any satisfactory result.

On the 13th February—being about the middle of the seventh month of her pregnancy—she was delivered of twins, a male and female, after

a tedious labour. Both children were dead, and partially decomposed. She was attended for me by Dr. Symes, of Kingstown, who thus writes about her case:—"The children appeared to be dead for some days, as the cuticle was peeling off. There were two placentæ, each very large and very soft, and a very large quantity of liquor amnii with each of the children."

About a week before labour I saw and carefully examined this lady, who was then confined to bed, and suffering extreme distress and annoyance from the group of symptoms I have already pointed out. The abdomen was much distended. I regret much I did not measure it; but certainly it was large even for the full term of pregnancy, though this was still nearly three months distant. No fœtal heart could be detected, nor fœtal movement felt. On vaginal examination I was surprised to find the presenting head in close apposition with the os uteri, and not to be displaced by any ordinary pressure of the finger. Relying on this diagnostic, I ventured to predict to her husband and friends "that she would most probably give birth to twins," which, as already stated, turned out perfectly right, and confirms the correctness of the observation I made on this diagnostic point in my original memoir, published seventeen years ago.[a] I would just remark here that both in this and the former case occasional hardening, or contraction, of the uterus, was perceptible long before the accession of labour. This sign would help us to differentiate, in any doubtful case, between ascites or ovarian tumour, and dropsy of the amnion.

My failure to arrest the disease after the symptoms of its presence had manifested themselves is only what has fallen to the lot of all other practitioners, I believe. When this form of dropsy sets in at any considerable period before the end of the ninth month—*e. g.*, at the beginning or middle of the sixth month of utero-gestation—the life of the fœtus will, pretty surely, be compromised; but where the dropsy does not arise till near the end of pregnancy, there is some chance for the child. In any case, however, this complication must be regarded as exercising a most prejudicial influence upon fœtal life. In none of the cases falling under my notice where, apparently, pre-natal treatment was successful in preserving the life of the fœtus, this amniotic dropsy did not enter into the case, whilst in the cases I have here recorded, and others that could be adduced, all treatment has signally failed to preserve the child when the hydropic condition was present.

In neither of the patients, whose cases are reported in this paper, was there the remotest reason to suspect the existence of constitutional syphilis, and this is quite in accordance with my previous experience of the complaint.

I have just mentioned that hydrops amnii is frequently associated

[a] Clinical Memoirs on Diseases of Women, p. 330.

with the death of the fœtus. In proof of this it may be mentioned that of 43 children born where the disease existed, 20 were born dead, and 16 of these had ceased to live some days or weeks before labour set in, and 11 of those born living died within a few days after birth. These facts are very striking, and tend to invest the disease under consideration with a high degree of importance. The question here arises—Is this fatality a consequence of the dropsy, or an effect in common with the dropsy, of some antecedent pathological change going on in the placenta, the sole organ of fœtal nutrition? The latter is the view I hold, though unable to produce any demonstrative evidence in support of it.

I have stated that medical treatment, so far as I am aware, seems incapable of arresting this intra-uterine disease. Iron, the salts of potassium, diuretics, digitalis, purgatives, febrifuges, anodynes, and mercury, have all been tried and found useless, or worse than useless. Arsenic is the only drug that seems to hold out any prospect of being serviceable, but I have not tried it, nor do I know if any one else has done so. The induction of premature labour might prove a valuable alternative, but should be restricted to cases where the symptoms appear late in the seventh month, or subsequently, in order that the child may be viable at birth. It was plainly inadmissible in the foregoing cases, so far as the interests of the fœtus were concerned.

Let me now bring this paper to a conclusion by very briefly summing up the general results of all the cases of amniotic dropsy coming under my cognisance, and of which I preserved notes.

Their total number amounts to 43; 4 of the mothers died. In 23 instances labour came on prematurely; 32 of the children were females, and 13 were males; 20 of the children were dead born, of whom 16 were in a more or less decomposed state. In only 36 instances was the presentation noted, of which 25 presented the head, 10 the pelvic extremity, and 1 the upper extremity.

Dr. Purefoy.—Some years ago a case came under my observation of a woman who had had one or two healthy children, and two or more afterwards still-born. I had some suspicion of the existence of lues venerea, but no definite grounds. The woman came under my care for an enlarged uterus, and shortly afterwards became pregnant. After three months she became troubled with a pain in her side, indicating a diseased condition of the placenta. Owing to having seen Dr. M'Clintock's observations on the subject, I treated her with chlorate of potassium and tincture of iron. After taking these medicines for a few weeks the pain subsided, and she went on to delivery and had a tolerably healthy child, although it had some affection of the palms of the hands and soles of the feet. She has had another healthy child since.

DR. HENRY KENNEDY.—An anonymous letter appears in the "Transactions of the College of Physicians," in which attention was for the first time directed to the fact of children being born alternately healthy and diseased. Some of the cases mentioned in that letter are exactly like those which Dr. M'Clintock has mentioned.

DR. KINKEAD.—A short time ago a case bearing on this subject came under my notice. It was that of a healthy young woman of a respectable class, from the country, whose husband had always been healthy, and there was no reason to suspect venereal in either of them. I did not attend her in her first confinement, but ascertained that her child died four or five days after its birth. I attended her in her second confinement, and saw her six weeks before her time was up. She was then of an enormous size, had a difficulty in lying down, and a pain in her side. Her labour came on by the waters escaping suddenly while she was out walking. She came home and had a rapid labour, and after the child was born there was the most enormous gush of water I ever saw. There was a tendency to hæmorrhage. After she became pregnant of her next child I put her on chlorate of potassium and tincture of iron, and she was afterwards delivered of a healthy child. The child of her next confinement was a miserable badly nourished infant, and died within two days after its birth. Its circulation was so bad that if you put it lying on its side its under-limb would become black. In her confinement after that the woman had a strong healthy child.

DR. ROE.—A few months ago I was called to see a lady who became suddenly very large when she was about six and a half months pregnant. After making a careful examination I concluded she was suffering from dropsy of the amnion. On making a vaginal examination I found a head presenting, but could feel no membranes whatever. The os was not much dilated. On the following day I had a consultation with Dr. Kidd, when, on making a vaginal examination, we found a child lying in the vagina. There had been a good deal of pain all the previous night, and a large quantity of water had come away. I took away this child. It appeared to be of about six months, and was somewhat decomposed—having, I believe, been dead for some time. The membranes of another child then presented, which I ruptured. There was now a fearful gush of water, amounting in quantity to fully seven quarts. Another child presented, by the feet, which I delivered; it was about the same size as the first, and was also decomposed. The two placentæ, which were very small, came away together without any difficulty. The uterus did not contract very rapidly, and a good deal of bleeding ensued, but the patient made a very good recovery. This lady has had several healthy children and never had a miscarriage, and there was no reason to suspect the existence of syphilis.

DR. M'CLINTOCK (in reply).—In my former memoir I called the disease

*dropsy of the ovum*, in order to include cases where the accumulation of fluid was within the chorion and external to the amnios. I do not deny that syphilis might be the cause of the disease; I only say that in the cases I have brought forward there was nothing to justify the supposition of there having been any syphilitic taint.

The Society then adjourned.

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*Saturday, May 1, 1880.*

E. B. SINCLAIR, A.M., M.D., President, in the Chair.

*Craniotomy and its Alternatives.*

The discussion on Dr. Kinkead's paper on "Craniotomy and its Alternatives," which had been adjourned, took place.

DR. KIDD.—It must be apparent to everyone who has watched the progress of obstetric opinion, that there has been a well-marked desire manifesting itself for many years past to avoid, as far as possible, the operation of craniotomy. Dr. Kinkead's paper has brought into a focus the opinions bearing on the subject, showing in a manner, that, I hope, will burn itself into the minds of all, that the operation is one always to be approached with hesitation and great reluctance. The question Dr. Kinkead has brought before us is as to the performance of craniotomy or alternative operations in cases of extreme narrowing of the pelvis; but before entering on this subject, I must, to avoid the risk of misapprehension, draw your attention to a class of cases to which he has not thought it necessary to allude. There are cases in which the diminution of the pelvis is not so great as in those alluded to by Dr. Kinkead, but in which the child could not pass through the pelvis in an unmutilated condition. It is impossible to fix exactly the limits of dimensions in these cases. Authors variously mention antero-posterior diameters of from 3½ inches to 3 inches, or less, as the smallest through which a living child may pass. At the bedside I believe this difficulty can never arise, where you can have opportunities of comparing the size of the head lying above the pelvis with the size of the pelvis itself, and can apply a forceps carefully once or twice, besides having the assistance of a person in whose judgment you have confidence. If we are once satisfied, after due and careful trial, that we cannot bring the head through in an unmutilated condition, and that delivery can be easily and safely effected by the operation of craniotomy, I maintain that it is our duty to lessen the head, and to deliver the woman. I say this, viewing the question from a purely obstetric point of view, which is the only one that we here, and in this Society, are called on to consider. We hear that the danger of craniotomy is greater than that of Cæsarean section; and that applies, it is true, to extreme cases, but not to the cases of which I speak.

In the cases of which I speak it has been shown conclusively by Dr. M'Clintock that the danger of craniotomy is really not as great as the danger of delivery by the forceps, provided it be done judiciously, and before the patient's condition has been so run down that she would probably die, no matter what operation was performed. We come now fairly to the question of the danger of craniotomy in cases of extreme narrowing of the pelvis. Dr. Kinkead has shown that all the great leaders of obstetric medicine have been fully aware of the great danger and difficulty attending the operation of craniotomy, and are, therefore, ready to discuss Cæsarean section, or any modified form of it, as a substitute. It is important to note that these cases are of rare occurrence. Early in my connexion with the Coombe Hospital I came to the determination that if ever I met with a case of this kind, I would very carefully consider the propriety of performing Cæsarean section, instead of proceeding to craniotomy; and I remember a conversation with you, Mr. President, as one of the consulting accoucheurs to the hospital, in which you said you were prepared to stand by me in performing Cæsarean section. I mention this to show that I am not prejudiced against Cæsarean section; on the contrary, I believe craniotomy, under such circumstances, is attended with extreme danger to the mother. Fortunately, however, as I have said, such cases are of very rare occurrence. I have been for thirty-two years more or less closely connected with the Coombe Lying-in Hospital. During that period 2,000 patients on an average were delivered under our care in each year; and, looking back on those years, I can only call to mind one case in which the present question would have arisen. I have already put that case on record. Had that woman come to the hospital with a living child in her womb, I would have canvassed very carefully the question of how she was to be delivered. But she was brought from the Dublin mountains on an ass's cart, with the child, which had presented as a footling, hanging out from the vulva, its head above the brim of the pelvis, the neck torn through, and the body attached to the head only by a fragment of skin. In such a case, of course, the alternative of Cæsarean section or craniotomy could not arise. She had exostosis of almost every bone in her body, one of which grew from the sacrum, and obstructed the brim of the pelvis. I delivered her with the cephalotribe, and she recovered without any bad symptoms, and left the hospital in a fortnight. After the most careful examination that we could make of her on that occasion, we found that she had an antero-posterior diameter of the brim of not two inches. Her case greatly modified my opinion on the question of Cæsarean section. She came back twice after that to the hospital, and on those occasions also I delivered her safely, and she recovered without any bad symptom. When she was last in the hospital I told her that this work of killing children was one that must be stopped, and that it was her bounden duty

to avoid the risk of pregnancy. Her husband seemed satisfied, but they must have changed their minds, for I heard that she afterwards became pregnant, and died undelivered. I believe the question of craniotomy or Cæsarean section to be one that must be decided by each man's own experience, and that it cannot be decided by any statistics that have been produced. If I could deliver a woman with a cephalotribe, I would be sorry to expose her to Cæsarean section in any of its forms; so that, notwithstanding the statistics laid before us by our American brethren, and so ably collected by Dr. Kinkead, I do not accept the proposition that, even with so narrow an antero-posterior diameter as two inches, it is our duty, without considering anything else, to perform Cæsarean section. Dr. Kinkead has alluded to cases where labour is obstructed by a tumour lying in the pelvis. I have twice brought that subject before the Society myself. The same rule, I think, applies to such cases as to those of narrowing of the antero-posterior diameter. If you have a tumour occupying the brim of the pelvis which you cannot push away, or diminish in size by tapping, the question of Cæsarean section or craniotomy very fairly arises. Under such circumstances, I believe Cæsarean section would probably afford the mother a better chance than dragging the child through the pelvis, lacerating or bruising the tumour, and perhaps setting up inflammatory action. But if it should be found that there was reasonable room for bringing the child through, I would hesitate very much, even in that case, before performing Cæsarean section. But, as I have said, the question must be decided not by statistics, but by the circumstances of each case. The same thing applies to the third class of cases that has been referred to. If you have malignant disease of the uterus, with the cervix greatly thickened and hardened, and perhaps a scirrhous mass developed in it, and the woman is in labour, you will perhaps deliver the woman more easily, and give her a better chance of prolonging her life, by performing Cæsarean section than by attempting craniotomy. But if it be a case of epitheliomatous disease, with no great induration or surrounding infiltration of the tissues, you will probably deliver her more safely by craniotomy than you would by Cæsarean section. But I do not think it is possible to lay down any rule on the subject. The facts of each case must determine what is the mode of procedure to be adopted. As to the mode in which the Cæsarean operation should be performed—whether you should cut down through the abdomen, open the vagina, and deliver through the os uteri, or whether you should remove the whole uterus along with the child—I have formed no definite opinion. I have had no experience; but looking at the matter *à priori*, and from the descriptions I have read of the three kinds of operations, I am inclined to think that the easiest operation, and the one likely to be attended with the best results, would be the old-fashioned Cæsarean section.

Dr. M'Clintock.—Although I have been for thirty-seven years actively engaged in the practice of midwifery, and during eleven years of that time in an hospital where there were a great number of deliveries annually, I never but on two occasions came across cases in which the question of Cæsarean section could really for one moment be entertained. In this country the occurrence of extreme contraction of the pelvis is very rare. Dr. Kidd's experience and my own give only three cases where the question of Cæsarean section could have been seriously entertained. Where there is only a slight degree of deformity of the pelvis, it requires a great amount of judgment to decide on the course to be pursued. But if you meet a moderately undersized pelvis, and if attempts by turning fail to extract the head and you know the child has ceased to live, one need not then hesitate to resort to perforation. But supposing that the forceps has been tried and has failed, and that turning is impracticable, what are you to do? I agree with Dr. Kidd that in such a case no man of sense would think of proposing Cæsarean section. Here is a woman who has been a considerable time in labour, and if she be now subjected to hysterotomy no chance of life would remain; whereas by the performance of craniotomy there is every human probability that her life would be saved. We are indebted to Dr. Kinkead for bringing before us Porro's operation, which is hardly known in this country. No doubt the desire of obstetricians for many years past has been to lessen the frequency of embryulcia, and in that desire I heartily concur. Every man having the honour of the profession at heart should do his utmost to remove from the category of operations one so revolting to every feeling of our nature. At the same time I am not so sanguine as to expect that it ever will be entirely removed. With regard to the diminution in the frequency of this disagreeable operation I may say that the rising generation may congratulate themselves on the great progress in that direction which has been made during the last fifteen or twenty years by the early use of the forceps. So far as I can form an opinion, without having had direct experience, I agree with Dr. Kinkead that craniotomy, in cases of extreme pelvic deformity, has been attended with nearly as large a rate of mortality as Cæsarean section performed *early* in labour. A large number of statistics bring this result out. With respect to Porro's operation, Dr. Harris, in a report published in *The American Medical Journal*, has collected 36 cases, in 18 of which the mothers recovered and 32 of the children were saved. These results certainly, as far as statistical results go, incline me to that operation.

Dr. Darby.—I think that in those rare cases alluded to by Dr. Kidd and Dr. M'Clintock, where the woman has a bony exostosis or tumour in the passage, I would be disposed to perform Cæsarean section, and give both mother and child a chance, although it might be a bad chance for both under the circumstances.

Dr. Dill.—I quite agree with everything that Dr. Kidd has said, except in one point. He said that after having delivered his patient a third time safely, he sent her home with instructions not to become impregnated again. That way of putting it goes to the root of the whole subject. I would say, that instead of giving her loose, indefinite instructions on the subject, the second party should be given instructions also.

Dr. MacSwiney.—It seems to me that gentlemen have not sufficiently kept in view that Dr. Kinkead's paper simply puts before us the question of craniotomy on the one side, and its alternatives on the other. Dr. Kidd has laid down the recognised dictum, that in those cases where delivery cannot be effected by the forceps, after one or more efforts, recourse must be had to craniotomy. That is the rule laid down at present. That is, of course, attended with results in the highest degree favourable to the mother, and the question with regard to the infant does not arise. But there is another class of cases in which the deformity is so extreme that the result to the mother is not by any means so favourable as in the first case. The scope of Dr. Kinkead's paper appears to me to be that sufficient attention has not been directed to the question as to whether it is not more advisable, having regard to the safety of the mother and the possible safety of the child, to have recourse to Cæsarean section rather than attempt the dangerous operation of craniotomy. He seems to challenge the dictum of obstetric surgery which says that the operation of craniotomy is a proper one to perform, and, in challenging it, he suggests that the reason why Cæsarean section has been attended with such unfavourable results in this kingdom is, that it is not performed in proper time, and when there is a fair chance of its proving beneficial to the mother. What I understand him to say is, that the Cæsarean operation has never received a fair trial in these kingdoms, contrasting it with the operation of craniotomy in those cases where craniotomy or its alternatives must be performed. I do not think that either Dr. Kidd or Dr. M'Clintock have addressed themselves sufficiently to this suggestion. The mortality from Cæsarean section in this country has been, no doubt, very great. The objectors to it urge that enormous mortality of the mothers and the very few children that are saved. Dr. Kinkead suggests that that mortality is so enormous because the operation is not performed in proper time; and the effect of his paper, I think, is that obstetricians must either show that he has not made out a case for Cæsarean section, even when performed under favourable circumstances, or must admit that they are bound to resort to that operation, performing it at a proper time, rather than to craniotomy.

Dr. Kidd.—I fear I have misconveyed my meaning. I have always been ready to consider Cæsarean section in cases of extreme narrowing. At the same time, judging from my experience of the only case I ever had of extreme narrowing, the tendency of my mind is in favour of craniotomy.

The PRESIDENT.—I wish to say one or two words on this important subject. Having a large class of young men to teach, this question has often struck my mind most forcibly. Cases will occur in the practice of midwifery where operative interference becomes necessary. In one class the forceps is tried, and it is found that no power we can use with it will bring forth the head. Though in such cases craniotomy is facile—in fact, an operation which will not in the least compromise the safety of the mother—are we in such to perform Cæsarean section? There are other cases in which the forceps fails, yet the narrowing is not so great as would make craniotomy very serious to the woman, although it would be more so than in the previously-described class. Are we to cut the woman open in these cases? I say certainly not. She has hardly any chance of losing her life by the operation. But when we come to cases of extreme narrowing, where craniotomy cannot be performed without lacerating the parts, and where we find from examination that the operation would be so seriously dangerous to the woman that in all probability she would die under or after it, then Cæsarean section ought to be performed in preference to craniotomy. With regard to the mortality from craniotomy, the fair way to state it is this:—In the first two classes of cases I have mentioned the mortality from craniotomy is almost *nil*, while in cases of extreme narrowing it is not even 1 to 4, but 1 to 2. These are the cases where Cæsarean section comes in as an operation of selection. If, as in the case of the unfortunate woman mentioned by Dr. M'Clintock, the narrowing is of such a degree as $2\frac{1}{2}$ inches or 2 inches, craniotomy would be obviously almost certain death to her. Would she not have a better chance of life with Cæsarean section? As good a one almost as a woman who is cut for dropsy of the ovary. I think that in all cases where extreme narrowing exists, Cæsarean section should be an operation of election and not one of *dernier ressort*. I have taught that in my class for years, and if I were to have such a case in my extern maternity, I should bring the woman into hospital, and at once, if permitted, perform Cæsarean section. Where you have a narrowing of the pelvis coming to 2 inches, I say that craniotomy is fraught with so great danger as involving almost certain death to the woman, and in such a case you should have no hesitation in performing Cæsarean section *at once*—you should not procrastinate, but perform the operation the moment her labour sets in. If you do you will doubtless have success. In one case of great narrowing which Dr. Johnston and I have recorded, craniotomy was, after consultation, performed, the parts were lacerated, and immediate death was the result. If Cæsarean section had been performed at once we would probably have saved her life and that of her child. I do not deal at all with the question from a religious point of view. That is not my province. Of course when the child is known to be dead craniotomy may be performed without hesitation, but

it is a terrible thing to have to kill the child in order to save the mother, though such a contingency very rarely occurs. In my opinion, when there exists extreme deformity, your best chance of saving both mother and child is to perform Cæsarean section as soon as labour sets in. It is fortunate, however, that in this country we have so few cases of such deformity. I do not know how long it is since I performed craniotomy, although I have 600 poor people delivered under my care every year. I believe, as I have said, that the reason why we have failed in this country with Cæsarean section is, because we have delayed the operation instead of performing it at once.

Dr. Kinkead (in reply).—In comparing craniotomy with its alternatives I thought I had made it sufficiently clear that I excluded cases of very narrow pelvis. I have not dealt with the question from a religious point of view at all, but simply as a physiologist. We should judge of the operation in the same way as if the lives of two adults were in question, and we had to choose that proceeding which would give us the best assurance of saving the life of at least one of them. I thought I had excluded from the discussion those cases where the size of the pelvis is so great that no danger to the mother is involved in extracting the child by craniotomy. The average size, according to the several standard works, below which it is laid down that craniotomy should be performed, is three inches by one and a half. I have endeavoured to show that the limit below which that operation should be undertaken should be placed higher than that. Dr. MacSwiney has hit off pretty much what I intended to convey when he said that Cæsarean section should be undertaken before the uterine tissues have undergone change from long-continued labour and the mother has become exhausted. My impression had been that Cæsarean section was almost necessarily fatal to the mother, but that impression was altered after I read a paper by Dr. Harris in *The Medical Press*, giving an account of a case in which there was a debate as to what were sufficient signs of the death of the child—failure of the fœtal heart, or absence of the placental bruit; and as craniotomy was rejected and no one had the courage to perform Cæsarean section, the woman and her child died. It seems rather a disgrace to our profession that a woman and her child should have been thus left to die. If craniotomy was not performed it is quite plain that Cæsarean section ought to have been. If we investigate the question of mortality in Cæsarean section we find, especially from the writings of Harris, that where it is done early the mortality is infinitely below what is generally supposed to be the case. In fact out of 32 cases that he has collected the mortality was only 25 per cent. Spencer Wells says the mortality, with proper precautions, is only 7 per cent. Collins records 79 cases of craniotomy and 15 deaths; Dunne 10 cases with 5 deaths; and Johnston, in his last report, 28 cases with 7 deaths. If we could

reduce the ratio to anything like that of ovariotomy, it would be our duty to perform Cæsarean section. I had hoped to hear some reasons adduced as to why that operation has been hitherto so fatal, but that, I think, has been overlooked. The question as to whether it would not be less fatal if it were performed in proper time and with proper precautions, instead of hurriedly, without antiseptic precautions and without waiting until the contraction of the uterus had ceased, has not been dealt with in the present discussion.

The Society adjourned.

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## TUBERCULOUS INFLAMMATION OF THE INTERNAL COAT OF VESSELS IN TUBERCULAR MENINGITIS.

BESIDES the anatomical changes that take place in the lymphatic spaces and outer coat of the vessels of the pia mater, M. Cornil has demonstrated that the inner coat is the seat of a special pathological process. It is thickened by the formation of several layers of cells which, beginning next the middle coat and going towards the endothelium, present the following form and disposition:—1. Small round cells enclosing small round nuclei. 2. Closely adjoining these are elongated cells of a cylindrical or prismatic shape, and terminated by a filiform extremity which is inserted in the elastic coat. 3. Cells of a large size (giant cells), often flattened out, of the shape of irregular plates, containing two or three ovoid nuclei. 4. Within the zone of giant cells there exist also prismatic cells or small round cells, irregularly placed, and forming a layer immediately subjacent to the endothelium. Thus the cells of the new formation in the inflamed lining membrane form, says M. Cornil, a true evolution, like that of epithelium, ending with giant cells as the highest of the series. The prismatic cells are the same as are found in ordinary inflammation, subacute or chronic, of the internal coat and in syphilitic inflammation of the arteries. This tubercular inflammation ending in giant cells is spread over the surface of the interior of the vessel, and does not affect the form of the limited granulations. The combination of the lesions of the connective tissue of the meninges, of the perivascular spaces, and of the vascular coats constitute the little nodules or the larger tuberculous masses. In several cases of meningitis where he had carefully searched for giant cells, so common in tubercle of other organs, he found them only in the altered inner coat of the vessels. These tuberculous alterations in the inner coat of the vessels strongly support the doctrine of the infection of tubercle, as the blood itself could thus be a carrier of the infective matter.—*Revue Médicale.*

S. W.